	FOR OHF USE				

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE

IMPORTANT NOTICE

OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I.	IDPH Facility ID Number: 000 Facility Name: Champaign County Nurs	01636			II. CERTI	FICATION BY	AUTHORIZED FACILIT	Y OFFICER	
	Address: 1701 East Main St. Urbana Number City County: Champaign		61802-2836 Zip Code		and cer are true applica	tify to the best e, accurate and ble instructions	of my knowledge and belief complete statements in acc Declaration of preparer (c	that the said contents ordance with other than provider)	
	Telephone Number: (217) 384-3784 IDPA ID Number: 366006910001	Fax # (217) 337-0120			Inter	ntional misrepre cost report may	esentation or falsification of be punishable by fine and/	any information	
	Date of Initial License for Current Owners: Type of Ownership:	04/26/1905	_		Officer or Administrator of Provider	(Signed)(Type or Print	Name) Jeremy Maupin	(Date)	
	VOLUNTARY,NON-PROFIT Charitable Corp. Trust	PROPRIETARY X Individual Partnership		ERNMENTAL State County		(Title) Adm (Signed)	inistrator SEE ACCOUNTANTS' C	COMPILATION REPORT	
	IRS Exemption Code	Corporation "Sub-S" Corp. Limited Liability Co. Trust		Other	Paid Preparer	(Print Name and Title)		(Date)	
		Other				(Firm Name & Address) (Telephone) MAI	Altschuler, Melvoin and One South Wacker Drive. (312) 634-3400 L TO: OFFICE OF HEALT	, Suite 800, Chicago, IL 60606 Fax # (312) 634-5518	
	In the event there are further questions about this report, please contact: Name: Michael W. Martin Telephone Number: (312) 634-3400 Please send copies of desk review and audit adjustments to address on this page					ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630			

STATE OF ILLINOIS Page 2

Faci	lity Name & ID Numb	er Champaign (County Nursing Hon	ne			# 0001636 Report Period Beginning: 12/01/2002 Ending: 11/30/2003
	III. STATISTICAL	L DATA					D. How many bed-hold days during this year were paid by Public Aid?
	A. Licensure/c	ertification level(s) of	f care; enter numbei	of beds/bed days,			(Do not include bed-hold days in Section B.)
	(must agree v	with license). Date of	change in licensed b	eds	N/A		
		ŕ	S	_		_	E. List all services provided by your facility for non-patients.
	1	2		3	4		(E.g., day care, "meals on wheels", outpatient therapy)
							Adult Day Care; Child Day Care
	Beds at				Licensed		
	Beginning of	Licensu	re	Beds at End of	Bed Days During		F. Does the facility maintain a daily midnight census?
	Report Period	Level of		Report Period	Report Period		17 Does the memory manning a daily manight census.
	Report Feriou	Lever or	carc	Report I criou	Report Feriou		G. Do pages 3 & 4 include expenses for services or
1	153	Skilled (SNI	E)	153	55,845	1	investments not directly related to patient care?
2	133		atric (SNF/PED)	133	33,043	2	YES X NO Non-allowable costs have been
3	56	Intermediat		56	20,440	3	eliminated in Schedule V, Column 7
4	30	Intermediat	,	30	20,440	4	H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
5	34	Sheltered C		34	12,410	5	YES X NO
6		ICF/DD 16	. ,		12,110	6	
		Tel/DD 10	or Ecss			1	I. On what date did you start providing long term care at this location?
7	243	TOTALS		243	88,695	7	Date started 1943
				•			
							J. Was the facility purchased or leased after January 1, 1978?
	B. Census-For	the entire report per	riod.				YES Date N/A NO X
	1	2	3	4	5		
	Level of Care	Patient Days	by Level of Care an	d Primary Source of	Payment		K. Was the facility certified for Medicare during the reporting year?
		Public Aid				1	YES X NO If YES, enter number
		Recipient	Private Pay	Other	Total		of beds certified 153 and days of care provided 5,537
8	SNF	888	891	5,537	7,316	8	
9	SNF/PED					9	Medicare Intermediary AdminaStar Federal
10	ICF	37,313	24,985		62,298	10	
11	ICF/DD	,	Í			11	IV. ACCOUNTING BASIS
12	SC	1,420	2,790		4,210	12	MODIFIED
13	DD 16 OR LESS					13	ACCRUAL X CASH* CASH*
14	TOTALS	39,621	28,666	5,537	73,824	14	Is your fiscal year identical to your tax year? YES X NO
	C Percent Occ	eunancy (Column 5	line 14 divided by to	ital licensed			Tax Year: 11/30/2003 Fiscal Year: 11/30/2003
	C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.23%						* All facilities other than governmental must report on the accrual basis.
				= 	SEE ACCOUNTAN	NTS' CO	OMPILATION REPORT

STATE OF ILLI	NOIS				Page 3
#	0001636	Report Period Beginning:	12/01/2002	Ending:	11/30/2003

E 'I' N O IDN I		4 NT . TT		STATE OF ILI		D (D)	ъ	12/01/2002	Б 11	Page 3	
Facility Name & ID Number	Champaign Co			#	0001636	Report Period	Beginning:	12/01/2002	Ending:	11/30/2003	_
V. COST CENTER EXPENSES (thro	ughout the report	<u>, please round t</u> Costs Per Gener	to the nearest d	ollar)	Reclass-	Reclassified	Adjust-	Adjusted	EOD OHI	USE ONLY	_
On anoting Ermanass	Salary/Wage		Other	Total	ification	Total	ments	Aujusteu Total	FOR OH	USE ONL I	
Operating Expenses	Salary/wage	Supplies 2		1 0tai 4			ments 7**		0	10	
A. General Services	723,419	73,924	3 23,939	•	5	6		8	9	10	٠.
1 Dietary	723,419		23,939	821,282		821,282	(3,502)	817,780			1
2 Food Purchase	207.007	456,164		456,164		456,164	(23,071)	433,093			2
3 Housekeeping	385,085	28,534		413,619		413,619	(2,595)	411,024			3
4 Laundry	129,251	26,221		155,472		155,472		155,472			4
5 Heat and Other Utilities			326,921	326,921		326,921	(28,348)	298,573			5
6 Maintenance	72,606	12,264	92,037	176,907		176,907	(8,633)	168,274			6
7 Other (specify):*											7
8 TOTAL General Services	1,310,361	597,107	442,897	2,350,365		2,350,365	(66,149)	2,284,216			8
B. Health Care and Programs											
9 Medical Director			4,200	4,200		4,200		4,200			9
10 Nursing and Medical Records	3,633,899	225,591	150,694	4,010,184		4,010,184		4,010,184			10
10a Therapy	1,550	989	284,099	286,638		286,638		286,638			10:
11 Activities	200,025	266	4,164	204,455		204,455	(1,200)	203,255		1	11
12 Social Services	129,547	27		129,574		129,574		129,574		1	12
13 Nurse Aide Training											13
14 Program Transportation											14
15 Other (specify):* Day Care Expenses	320,203	2,091	4,922	327,216		327,216	(327,216)				15
16 TOTAL Health Care and Programs	4,285,224	228,964	448,079	4,962,267		4,962,267	(328,416)	4,633,851			16
C. General Administration											
17 Administrative	91,268		46,561	137,829		137,829	(1,041)	136,788			17
18 Directors Fees											18
19 Professional Services			31,993	31,993		31,993	(813)	31,180			19
20 Dues, Fees, Subscriptions & Promotions			25,248	25,248		25,248	(1,871)	23,377			20
21 Clerical & General Office Expenses	336,926	15,174	63,415	415,515		415,515	(1,941)	413,574			21
22 Employee Benefits & Payroll Taxes			1,380,978	1,380,978		1,380,978	(59,175)	1,321,803			22
23 Inservice Training & Education			2,289	2,289		2,289	(200)	2,089			23
24 Travel and Seminar			9,018	9,018		9,018	(797)	8,221		1	24
25 Other Admin. Staff Transportation			1,696	1,696		1,696	(14)	1,682		1	25
26 Insurance-Prop.Liab.Malpractice			209,705	209,705		209,705	(7,758)	201,947		1	26
27 Other (specify):*											27
28 TOTAL General Administration	428,194	15,174	1,770,903	2,214,271		2,214,271	(73,610)	2,140,661			28
TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,023,779	841,245	2,661,879	9,526,903		9,526,903	(468,175)	9,058,728			29
*Attach a schodula if more than one to						SEE ACCOUNT	ANTS! COMDI		т		

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000. SEE ACCOUNTANTS COMPILAT NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustments attached at end of cost report. SEE ACCOUNTANTS' COMPILATION REPORT

V. COST CENTER EXPENSES (continued)

			Cost Per Gener	al Ledger		Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			262,144	262,144		262,144	(32,669)	229,475			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			6,143	6,143		6,143		6,143			35
36	Other (specify):*											36
37	TOTAL Ownership			268,287	268,287		268,287	(32,669)	235,618			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		123,794		123,794		123,794		123,794			39
40	Barber and Beauty Shops	49,138	1,400		50,538		50,538		50,538			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			114,427	114,427		114,427		114,427			42
43	Other (specify):* Nonallowable Costs			59,174	59,174		59,174	(59,174)				43
44	TOTAL Special Cost Centers	49,138	125,194	173,601	347,933		347,933	(59,174)	288,759			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	6,072,917	966,439	3,103,767	10,143,123		10,143,123	(560,018)	9,583,105			45

^{*}Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

^{**}See schedule of adjustments attached at end of cost report.

Page 5 11/30/2003

4

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

0001636

	III COMMIN	2 Below	1	2	3	1 2030
			-	Refer-	OHF USE	
	NON-ALLOWABLE EXPENSES		Amount	ence	ONLY	
1	Day Care	\$	(327,216)	15	\$	1
2	Other Care for Outpatients					2
3	Governmental Sponsored Special Programs					3
4	Non-Patient Meals					4
5	Telephone, TV & Radio in Resident Rooms					5
6	Rented Facility Space					6
7	Sale of Supplies to Non-Patients					7
8	Laundry for Non-Patients					8
	Non-Straightline Depreciation					9
	Interest and Other Investment Income					10
	Discounts, Allowances, Rebates & Refunds					11
12	Non-Working Officer's or Owner's Salary					12
13	Sales Tax					13
	Non-Care Related Interest					14
_	Non-Care Related Owner's Transactions					15
	Personal Expenses (Including Transportation)					16
	Non-Care Related Fees		(30)	43		17
18	Fines and Penalties		(14,835)	43		18
-	Entertainment					19
	Contributions					20
21						21
22	Special Legal Fees & Legal Retainers		(24,551)	43		22
	Malpractice Insurance for Individuals		_			23
	Bad Debt		(19,187)	43		24
25	Fund Raising, Advertising and Promotional		(571)	43		25
	Income Taxes and Illinois Personal					
	Property Replacement Tax					26
27	Nurse Aide Training for Non-Employees					27
	Yellow Page Advertising		(153 (30)			28
	Other-Attach Schedule		(173,628)	var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$	(560,018)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		1	2
		Amount	Reference
31	Non-Paid Workers-Attach Schedule*	\$	31
32	Donated Goods-Attach Schedule*		32
	Amortization of Organization &		
33	Pre-Operating Expense		33
	Adjustments for Related Organization		
34	Costs (Schedule VII)		34
35	Other- Attach Schedule		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$	36
	(sum of SUBTOTALS		
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (560,018)	37

^{*}These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

1 2 3

	·	Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

	OHF USE ONLY	Y				
48		49	50	51	52	

Champaign County Nursing Home Facility #0001636 11/30/03

Page 5 - Line 29 - Other Non-Allowable Costs

Description	<u>Amount</u>	<u>Reference</u>
Kiwanis dues	(168)	20
Promotional advertising	(1,703)	20
Out of state seminars	(797)	24
Offset Candy fundraiser income	(1,200)	11
Inservice & Training	(200)	23
Daycare		
Dietary	(3,502)	1
Food	(17,153)	2
Housekeeping	(2,595)	3
Utilities	(28,348)	5
Maintenance	(8,633)	6
Administrative	(1,041)	17
Professional fees	(813)	19
Office expense	(1,941)	21
Employee benefits	(65,093)	22
Staff transportation	(14)	25
Insurance	(7,758)	26
Depreciation	(32,669)	30
	(173,628)	

STATE OF ILLINOIS

Page 5A

Champaign County Nursing Home

| ID# | 0001636 | | Report Period Beginning: | 12/01/2002 | | Ending: | 11/30/2003 |

Sch. V Line

			Sch. V Line
	NON-ALLOWABLE EXPENSES	Amount	Reference
1		S	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
43			43
44			44
45			45
46			46
47			47
48			48
49	Total		0 49
	0 4 1 1	Compilation Report	

See Accountants' Compilation Report

Summary A 12/01/2002 11/30/2003 Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: Ending:

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I SUMMARY **Operating Expenses** PAGES PAGE TOTALS A. General Services 5 & 5A 6A 6C 6D **6E** 6F 6G 6H **6I** (to Sch V, col.7) Dietary 0 1 0 2 Food Purchase 3 Housekeeping 0 3 Laundry Heat and Other Utilities Maintenance Other (specify):* TOTAL General Services B. Health Care and Programs Medical Director 0 9 Nursing and Medical Records 0 10a 10a Therapy 0 11 Activities 12 Social Services 0 12 13 Nurse Aide Training 0 13 Program Transportation 0 14 15 Other (specify):* (327,216) (327,216) 15 (327,216) TOTAL Health Care and Programs (327,216) C. General Administration 17 Administrative 0 17 Directors Fees 0 18 Professional Services 0 19 20 Fees, Subscriptions & Promotions 0 20 21 Clerical & General Office Expenses 0 21 22 Employee Benefits & Payroll Taxes 0 22 Inservice Training & Education 0 23 0 24 24 Travel and Seminar 25 Other Admin. Staff Transportation 0 25 26 Insurance-Prop.Liab.Malpractice 0 26 27 Other (specify):* 0 27 0 28 28 TOTAL General Administration **TOTAL Operating Expense** 29 (sum of lines 8,16 & 28) (327,216)(327,216) 29

STATE OF ILLINOIS Summary B

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/2002 Ending: 11/30/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

													SUMMARY	
	Capital Expense	PAGES	PAGE	TOTALS										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6Н	6I	(to Sch V, col	.7)
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(59,174)	0	0	0	0	0	0	0	0	0	0	(59,174)	43
44	TOTAL Special Cost Centers	(59,174)	0	0	0	0	0	0	0	0	0	0	(59,174)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(386,390)	0	0	0	0	0	0	0	0	0	0	(386,390)	45

Report Period Beginning:

12/01/2002 Ending:

11/30/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1		2		3			
OWNERS		RELATED NURSING HO	OTHER RELATED BUSINESS ENTITIES				
Name	Ownership %	Name	City	Name	City	Type of Business	
Champaign County	100	N/A		N/A			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	dire mistre	10113	for determining costs as specified	ior ting form.				0.75100	
	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
5011		2	10011	1 mount	Tume of Itemeter of Guinzarion	Ownership		Costs (7 minus 4)	
	*7	4.	m 6 •				0		_
1	V	17	Treasury Services	\$ 6,260	Champaign County	100.00%		\$	1
2	V	17	Auditor's Office Services	40,301	Champaign County	100.00%	40,301	2	2
3	V	22	IMRF	214,101	Champaign County	100.00%	214,101		3
4	V	22	FICA	445,796	Champaign County	100.00%	445,796	4	4
5	V	22	Workers Compensation Ins.	292,312	Champaign County	100.00%	292,312		5
6	V	22	Unemployment Insurance	45,901	Champaign County	100.00%	45,901	(6
7	V	22	Health Insurance	364,736	Champaign County	100.00%	364,736		7
8	V							8	8
9	V							9	9
10	V				Recorded on facility books and included on Schedule V, Column 3			1	10
11	V							1	11
12	V							1	12
13	V							1	13
14	Total			s 1,409,407			s 1,409,407	\$ * 1	14

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

Report Period Beginning:

12/01/2002

Ending:

11/30/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5		6	7		8	
						Average Ho	ırs Per Work				
					Compensation	Week Dev	oted to this	Compensati	on Included	Schedule V.	
					Received	Facility and	l % of Total	in Costs	for this	Line &	
				Ownership	From Other	Work	Week	Reportin	g Period**	Column	
	Name	Title	Function	Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1								•	\$		1
2	See attached list	Board of Directors	Administrative	0.00	None		<1%		None	N/A	2
3											3
4											4
5											5
6	Note: No board member prov	ided services to the nu	rsing home during	the reportir	ng period. No busir	ess entity ow	ned by a boa	rd member co	onducted busines	SS	6
7	transactions with the nursing	home during the repo	rting period.								7
8											8
9											9
10								•			10
11											11
12								•			12
13								TOTAL	\$		13

- * If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.
- ** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
 FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
 ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

STATE OF ILLINOIS Page 8

Facility Name & ID Number	Champaign County Nursing Home	# 0001636	Report Period Beginning:	12/01/2002	Ending: 1/30/2003	

VIII. ALLOCATION OF INDIRECT COSTS

	Name of Related Organization	Champaign County
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	1776 East Washington
or parent organization costs? (See instructions.) YES X NO	City / State / Zip Code	Urbana, IL 61802
	Phone Number	(217) 384-3776
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	(217) 337-0120

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	17		Direct Costs		All Co. Depts.	\$	\$	1	\$ 6,260	1
2	17	Auditor's Office Services	Direct Costs		All Co. Depts.			1	40,301	2
3	22	IMRF	Direct Costs		All Co. Depts.			1	214,101	3
4	22	FICA	Direct Costs		All Co. Depts.			1	445,796	4
5	22	Workers Compensation Ins.	Direct Costs		All Co. Depts.			1	292,312	5
6	22		Direct Costs		All Co. Depts.			1	45,901	6
7	22	Health Insurance	Direct Costs		All Co. Depts.			1	364,736	7
8										8
9										9
10										10
11				Recorded on fa	cility books and inclu	ded on Schedule V, Colu	mn 3			11
12										12
13										13
14										14
15										15
16										16
17										17
18 19										18
										19 20
20										
21										21
							ļ			
23							ļ			23
	TOT 1 T G								4 400 40	24
25	TOTALS					S	\$		\$ 1,409,407	25

STATE OF ILLINOIS Page 8A

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/2002 Ending: 1/30/2003

VIII. ALLOCATION OF INDIRECT COSTS

	Name of Related Organization	Champaign County Day Care
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	1701 East. Main St.
or parent organization costs? (See instructions.) YES X NO	City / State / Zip Code	Urbana, IL 61802
	Phone Number	(217) 384-3784
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	(217) 337-0120

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	1	Dietary	Meals	230,989		\$ 99,049	\$	8,167	\$ 3,502	1
2	2	Food	Meals	230,989		485,143		8,167	17,153	2
3	3	Housekeeping	Square Feet	63,455		27,075		6,082	2,595	3
4	5	Utilities	Square Feet	63,455		295,759		6,082	28,348	4
5	6	Maintenance	Square Feet	63,455		90,067		6,082	8,633	5
6	17	Administrative	Revenue	8,957,183		43,597		213,906	1,041	6
7	19	Professional Fees	Revenue	8,957,183		34,025		213,906	813	7
8		Office Expense	Revenue	8,957,183		81,260		213,906	1,941	8
9	22	Employee Benefits	Salaries	6,072,917		1,180,363		334,902	65,093	9
10	25	Staff Transportation	Revenue	8,957,183		590		213,906	14	10
11	26	Insurance-Auto	Direct Allocation	1		4,064		1	4,064	11
12	26	Insurance-Other	Revenue	8,957,183		154,681		213,906	3,694	12
13		Depreciation-Auto	Direct Allocation	1		7,028		1	7,028	13
14	30	Depreciation-Other	Square Feet	63,455		267,519		6,082	25,641	14
15										15
16										16
17										17
18		Day care cost eliminated on Sched	lule V - Column 7.							18
19										19
20										20
21									•	21
22		· ·								22
23										23
24		_								24
25	TOTALS					\$ 2,770,220	\$		\$ 169,560	25

Champaign County Nursing Home

0001636

Report Period Beginning:

12/01/2002 Ending:

Page 9 11/30/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	3	4	5	6	7	8	9	10	
	Name of Lender	Relate YES	Purpose of Loan	Monthly Payment Required	Date of Note	Amo Original	unt of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related			<u> </u>						•	
	Long-Term										
1						\$	\$		5	3	1
2			This Page Not Applicable								2
3											3
4											4
5											5
	Working Capital										
6											6
7											7
8											8
9	TOTAL Facility Related					s	\$		5	S	9
10	B. Non-Facility Related*		I	1	1		1	T			10
11									+ +		11
12											12
13									+		13
13											+ 13
14	TOTAL Non-Facility Related					\$	\$		9	3	14
15	TOTALS (line 9+line14)					s	\$		9	8	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.	\$	None	Line#	N/A
--	----	------	-------	-----

^{*} Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

^{**} If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

STATE OF ILLINOIS Page 10
0001636 Report Period Beginning: 12/01/2002 Ending: 11/30/2003

Facility Name & ID Number Champaign County Nursing Home

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

R Real Estate Taxes

B. Real Estate Taxes					
	Important, please see the next worksheet, "	'RE_Tax". The real	estate tax statement and		
1. Real Estate Tax accrual used on 2002 report.	bill must accompany the cost report.			\$	1
2. Real Estate Taxes paid during the year: (Indicate the	tax year to which this payment applies. If payment cove	rs more than one year,	detail below.)	s	2
3. Under or (over) accrual (line 2 minus line 1).				s	3
4. Real Estate Tax accrual used for 2003 report. (Detai	and explain your calculation of this accrual on the lines	s below.)		\$	4
5. Direct costs of an appeal of tax assessments which ha (Describe appeal cost below. Attach copi	s NOT been included in professional fees or other generes of invoices to support the cost and a co			\$	5
Subtract a refund of real estate taxes. You must offso classified as a real estate tax cost plus one-half of any TOTAL REFUND	3 11	l estate tax appea	board's decision.)	s	6
7. Real Estate Tax expense reported on Schedule V, line	233. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year: 1998	8		FOR OHF USE ONLY		
1999 2000	9 10	13	FROM R. E. TAX STATEMENT F	OR 2002 \$	13
2001 2002	11 12	14	PLUS APPEAL COST FROM LIN	E5 \$	14
County Facility: Does not pay real estate tax.		15	LESS REFUND FROM LINE 6	\$	15
		16	AMOUNT TO USE FOR RATE CA	ALCULATION \$	16

NOTES:

- 1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an
 application for real estate tax exemption unless the building is rented from a for-profit entity.
 This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FAC	ILITY NAME	Champaign County	Nursing Home		COUN	TY Chan	npaign
FAC	ILITY IDPH LIC	ENSE NUMBER 0	001636				
CON	TACT PERSON	REGARDING THIS	REPORT Amanda Kn	ight, Con	nptrolle		
TEL	EPHONE 217-38	343784		FAX #:	217-337-0120		
A.	Summary of Re	eal Estate Tax Cos					
	cost that applies home property v	to the operation of the	state tax assessed for 2 e nursing home in Col I to other organization cost for any period ot	umn D. 1 s, or used	Real estate tax appli for purposes other	cable to any	portion of the nursir
	(A)	(B)		(C)		(D) <u>Tax</u> Applicable to
	Tax Index	Number	Property Descrip	tion	Total 7	Гах	Nursing Home
1.	Facility does not	pay real estate taxes.			\$ N/A		\$
2.					\$		\$
3.					\$		\$
4.							\$
5.					_		\$
6.							\$
7.					\$		\$
8.							\$
9.					\$		\$
10.					\$		\$
			7	OTALS	\$		\$
B.	Real Estate Tax	Cost Allocations					
	Does any portion used for nursing		to more than one nurs YES	ing home		r property w	hich is not direct
			edule which shows the				

C. Tax Bills

 $Attach\ a\ copy\ of\ the\ 2002\ tax\ bills\ which\ were\ listed\ in\ Section\ A\ to\ this\ statement.\ Be\ sure\ to\ use\ the\ 2002\ tax\ bill\ which\ is\ normally\ paid\ during\ 2003.$

See Accountants' Compilation Report

Page 10A

					STATE OF ILLI	NOIS			Page 11
	ity Name & ID Number Champa		ng Home		# 00016	36 Report P	eriod Beginning:	12/01/2002 Ending:	11/30/2003
X. BU	JILDING AND GENERAL INFO	ORMATION:							
A.	Square Feet: 10	1,931 B. Ge	neral Construction Type:	Exterior	Brick	Frame	Reinforced Concre	te Number of Stories	2
C.	Does the Operating Entity?	X (a) O	wn the Facility	(b) Rent from	a Related Organiz	ation.		(c) Rent from Completely Unr Organization.	elated
	(Facilities checking (a) or (b) m	ust complete Scho	dule XI. Those checking (c) r	nay complete Schedu	le XI or Schedule	XII-A. See inst	ructions.		
D.	Does the Operating Entity?	X (a) O	wn the Equipment	(b) Rent equip	ment from a Relat	ed Organizatio	n.	(c) Rent equipment from Com Unrelated Organization.	pletely
	(Facilities checking (a) or (b) m	ust complete Scho	dule XI-C. Those checking (c	e) may complete Sche	dule XI-C or Sche	dule XII-B. See	instructions.	g	
E.	List all other business entities o (such as, but not limited to, apa List entity name, type of busine	rtments, assisted	living facilities, day training f	acilities, day care, in	dependent living fa				
	NONE								
F.	Does this cost report reflect any If so, please complete the follow		ore-operating costs which are	being amortized?			YES	X NO	
1.	Total Amount Incurred:		N/A		2. Number of Yea	rs Over Which	it is Being Amortize	d:	
3.	Current Period Amortization:				4. Dates Incurred	:			
			~ .		_				-
		Nature of	Costs: ch a complete schedule detail	ing the total amount	of organization an	d nre operating	r costs)		
		(Atta	en a complete schedule detail	ing the total amount	oi oi ganization an	u pre-operating	costs.)		
XI. O	WNERSHIP COSTS:								
			1	2	3		4		
	A. Land.	1	Use Resident care	Square Feet 1,859,520	Year Acquir	red 1865 \$	Cost 2,100	1	
		2	resident care	1,009,520		1002 3	2,100	1	
							J	2	

SEE ACCOUNTANTS' COMPILATION REPORT

Page 12 11/30/2003 Facility Name & ID Number Champaign County Nursing Home # 0001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar 0001636 Report Period Beginning: 12/01/2002 Ending:

	1	ng Depreciation-Including Fixed Eq	2	3	4	5	6	7	8	9	
	_	FOR OHF USE ONLY	Year	Year	-	Current Book	Life	Straight Line	_	Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4	153		1975	1973	s 2,085,435	\$ 52,136	40	s 52,136	S	s 1,577,111	4
5	56		1910	1971	734,760	,	25	,		734,760	5
6	34			1971	207,240		25			207,240	6
7	-		1989	1989	34,891	872	40	872		12,652	7
8					,,,,,					, , , ,	8
	Impro	ovement Type**					_				
9	Building impr			1972	10,300		25			10,300	9
10	Building impr	ovements		1973	146,645		25			146,645	10
11	Building impr	ovements		1974	288,473		25			288,473	11
12	Building impr	ovements		1974	18,482	462	40	462		13,568	12
13	Building impr	ovements		1975	25,353		25			25,353	13
14	Building impr			1976	6,342		15			6,342	14
15	Building impr			1977	3,399		15			3,399	15
16	Building impr			1977	8,548		25			8,548	16
17	Building impr			1980	2,469		15			2,469	17
18	Building impr			1981	36,818		15			36,818	18
19	Building impr			1982	57,322		15			57,322	19
20	Building impr			1983	31,084		10			31,084	20
21	Building impr			1984	223,985	9,344	24	9,344		182,212	21
22	Building impr			1985	57,958	2,953	20	2,953		53,173	22
23	Building impr			1986	254,092	10,164	25	10,164		177,865	23
24	Building impr			1987	81,739	4,153	20	4,153		68,533	24
25	Building impr			1988	345,563	13,823	25	13,823		214,250	25
26	Building impr			1989	64,947	2,598	25	2,598		37,670	26
27	Building impr			1990	251,292	10,052	25	10,052		135,698	27
28	Building impr			1991 1992	163,384	6,535	25	6,535		81,691 63,527	28 29
29	Building impr			1992	138,101 62,716	5,524 2,509	25 25	5,524 2,509		26,341	30
30	Building impr Building impr			1993	360,106	2,509 14,404	25	2,509 14,404		136,840	31
32	Building impr			1994	28,420	1.138	25	1,138		9,670	32
33	Building impr			1995	21,058	842	15	842		6,317	33
34	Parking lot	ovements		1977	25,035	072	15	072		25,035	34
35	i ai King iot			17//	43,033		13	-		43,033	35
36											36
30	1			1	l		l	1	1	1	30

^{*}Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total SEE ACCOUNTANTS' COMPILATION REPORT

^{**}Improvement type must be detailed in order for the cost report to be considered complete

l · ·	3	4	rest dollar 5	6	7	8	9	\neg
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
37 Tree care	1981	s 465	\$	15	s	\$	s 465	37
38 Landscaping additions	1982	1,870		10			1,870	38
39 Landscaping additions	1983	5,250		5			5,250	39
40 Landscaping additions	1987	3,491		5			3,491	40
41 Landscaping additions	1988	1,971	66	15	66		1,971	41
42 Landscaping additions	1989	6,125	392	15	392		5,905	42
43 Landscaping additions	1990	3,596	240	15	240		3,237	43
44 Landscaping additions	1991	11,069	738	15	738		9,230	44
45 Landscaping additions	1992	2,969	198	15	198		2,277	45
46 Parking lot expansion	1996	67,139	4,602	15	4,602		34,825	46
47 Smoke detectors	1997	4,524		5			4,524	47
48 Redecorating-ADC	1997	1,459		5			1,459	48
49 Sprinkler backflow preventor	1997	6,230	623	10	623		4,050	49
50 Fire door - Activity office	1997	626	63	10	63		408	50
51 Wall-Dietary	1997	705	70	10	70		457	51
52 Mini blinds - Dining area	1997	1,045		5			1,045	52
53 Tuckpointing - Administration bldg	1997	11,400	456	25	456		2,964	53
54 Flooring improvements	1997	3,306		5			3,306	54
55 Asbestos removal	1998	45,350	1,814	25	1,814		9,967	55
56 Project planning - ARD expansion	1998	35,513	3,551	5	3,551		35,513	56
57 Air conditioning - Chiller replacement	1998	193,611	9,272	20	9,272		51,429	57
58 Hot water treatment system	1998	1,422	143	5	143		1,422	58
59 Pipe insulation	1998	3,201	160	20	160		880	59
60 Door sensor beam	1998	567	57	5	57		567	60
61 Vanity replacement (wing)	1998	16,236	812	20	812		4,465	61
62 Shower tile replacement (B wing)	1998	1,064	71	15	71		390	62
63 Heat exchanger replacement	1998	4,417	442	10	442		2,430	63
64 Pipe insulation	1998	97	5	20	5		27	64
65 Asbestos removal	1998	4,792	192	25	192		1,055	65
66 Cable for computer	1999	7,350	490	15	490		2,205	66
67 Chiller replacement electrical	1999	3,465	173	20	173		779	67
68 Door alarm on B wing	1999	1,808	181	10	181		814	68
69 Carpet - 3 offices	1999	814	163	5	163		733	69
70 TOTAL (lines 4 thru 69)		\$ 6,228,904	\$ 162,483		s 162,483	\$	\$ 4,580,316	70

^{**}Improvement type must be detailed in order for the cost report to be considered complete

Page 12B 12/01/2002 Ending: 11/30/2003 Facility Name & ID Number Champaign County Nursing Home # 0001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment, (See instructions.) Round all numbers to nearest dollar # 0001636 Report Period Beginning:

B. Building Depreciation-Including Fixed Equipment. (See inst	ructions.) Koui	id an numbers to near	rest donar	6	7	8	1 9	
1	Year	7	Current Book	Life	Straight Line	o	Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
	Constructed	\$ 6,228,904	\$ 162.483	III I Cars	s 162.483	Aujustinents e	\$ 4,580,316	1
1 Totals from Page 12A, Carried Forward	1999	50	5 102,465	10	5 102,465	J	23	2
2 Door alarm hook-up					5			
3 Stainless steel wall coverings	1999	1,382	69	20	69		311	3
4 Flipper cabinet w/ hanging tracks	1999	297	20	15	20		90	4
5 Flipper cabinet w/ hanging tracks	1999	1,216	81	15	81		365	5
6 Door magnets (door alarms)	1999	144	14	10	14		64	6
7 Ceramic flooring	1999	3,192	160	20	160		719	7
8 Carpet in 2 offices	1999	918	184	5	184		827	8
9 Hollow metal door	1999	788	39	20	39		176	9
10 Annunciator	1999	400	40	10	40		180	10
11 Unit heater for bus ban	1999	569	38	15	38		171	11
12 Privacy panels & hardware	1999	518	104	5	104		467	12
13 A-wing nursing station	1999	4,333	289	15	289		1,300	13
14 Hook-up call system	1999	734	49	15	49		220	14
15 Computer cable	2000	810	54	15	54		203	15
16 Stainless folding for shower rooms	2000	578	58	15	58		217	16
17 Vinyl flooring	2000	960	192	10	192		592	17
18 Concrete fountain	2000	1,000	40	25	40		140	18
19 Remodel Annex corner	2001	443	87	5	87		196	19
20 Conversion of Activity room to Dining	2001	2,079	416	5	416		936	20
21 Major repair-Walk-in refrigerator	2001	526	105	5	105		219	21
22 Vinyl flooring	2001	898	180	5	180		367	22
23 Stairway treads	2001	1,495	299	5	299		610	23
24 Carpet - Canopy walkway	2001	980	196	5	196		408	24
25 Tree removal	2001	975	98	10	98		252	25
26 Fire alarm update	2001	1,273	127	10	127		360	26
27 Dishwasher fan	2001	4,285	429	10	429		1,144	27
28 ADC alarm	2001	566	57	10	57		152	28
29 Activity room phone system	2001	110	11	10	11		26	29
30 Wing door alarm	2001	886	89	10	89		222	30
31 Door alarm system	2001	857	86	10	86		208	31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 6,262,166	\$ 166,099		s 166,099	\$	s 4,591,481	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete

0001636

Report Period Beginning:

12/01/2002 Ending:

Page 12C 11/30/2003

Facility Name & ID Number Champaign County Nursing Home # 0001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

I (See list)	3	4	5	6	7	8	9	
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12B, Carried Forward		\$ 6,262,166	\$ 166,099		\$ 166,099	\$	s 4,591,481	1
2 Hollow doors (3)	2002	635	32	20	32		61	2
3 Hollow door (1)	2002	514	26	20	26		45	3
4 Smoke detectors in ductwork	2002	23,325	2,333	10	2,333		4,147	4
5 Ductwork repair per Life Safety survey	2002	20,469	2,047	10	2,047		3,581	5
6 Smoke detectors in ductwork	2002	15,829	1,583	10	1,583		2,441	6
7 Air conditioner condensing unit	2002	971	65	15	65		87	7
8 Garage Door Repairs	2002	565	38	15	38		48	8
9 Removal of trees	2002	1,800	180	10	180		200	9
10 Sprinkler System Repair	2003	1,569	63	25	63		63	10
11 Compressor - Air Conditioner	2003	27,800	927	15	927		927	11
12 Heat Exchanger Repair	2003	5,559	31	15	31		31	12
13								13
14 15								14 15
16								16
17								17
18								18
19								19
20 Less: Allocated to Day Care			(32,669)		(32,669)			20
21 Less: Anocated to Day Care			(02,00)	1	(52,007)			21
22								22
23								23
24				1				24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32							•	32
33		·						33
34 TOTAL (lines 1 thru 33)		\$ 6,361,202 SEE ACCOUNTAL	\$ 140,755		\$ 140,755	\$	\$ 4,603,112	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete

CTAT	TE OF	II I	INOIS

Page 13 # 0001636 **Report Period Beginning:** 12/01/2002 Ending: 11/30/2003 Facility Name & ID Number **Champaign County Nursing Home**

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	C. Equipment Depreciation-Excluding	Transportation: (See instructions.)	T =	T ~				
	Category of	1	Current Book	Straight Line	4	Component	Accumulated	
	Equipment	Cost	Depreciation 2	Depreciation 3	Adjustments	Life 5	Depreciation 6	
71	Purchased in Prior Years	\$ 1,524,097	\$ 79	605 \$ 79,605	\$	3-15	\$ 1,286,512	71
72	Current Year Purchases	14,781	1	933 1,933		3-10	1,933	72
73	Fully Depreciated Assets	391,350					391,350	73
74								74
75	TOTALS	\$ 1,930,228	\$ 81	538 \$ 81,538	\$		\$ 1,679,795	75

D. Vehicle Depreciation (See instructions.)*

	1	Model, Make	Year	4	Current Book	Straight Line	7	Life in	Accumulated	
	Use	and Year 2	Acquired 3	Cost	Depreciation 5	Depreciation 6	Adjustments	Years 8	Depreciation 9	
76	Resident use	96 Ford Bus	1996	\$ 36,532	\$ 3,653	\$ 3,653	\$	10	\$ 27,400	76
77	Resident use	98 Dodge Van	1998	33,746	3,375	3,375		10	18,561	77
78	Resident use	Lift for Van	2001	537	107	107		5	250	78
79	Resident use	97 Ford	2002	1,898	47	47		10	94	79
80	TOTALS			\$ 72,713	\$ 7,182	\$ 7,182	\$		\$ 46,305	80

E. Summary of Care-Related Assets

	E. Summary of Care-Related Assets	1	2		
		Reference	Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,366,243	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 229,475	82	1
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 229,475	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,329,212	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1	2	Current Book	Accumulated	
	Description & Year Acquired	Cost	Depreciation 3	Depreciation 4	
86		\$	\$	\$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Design & legal fees for	\$ 170,406	92
93	new facility		93
94			94
95		\$ 170,406	95

Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

SEE ACCOUNTANTS' COMPILATION REPORT

** This must agree with Schedule V line 30, column 8.

XII.	 Name of Does the 	and Fixed Equi Party Holding			al amount shown below o		lno		
	11 110, 80	e msu ucuons.				ILS	INO		
		1	2	3	4	5	6		
		Year Constructed	Number of Beds	Date of Lease	Rental Amount	Total Years of Lease	Total Y Renewal C		
	Original	Constructed	oi beus	Lease	Amount	of Lease	Kellewal	ption"	10. Effective dates of current rental agreement:
3	Building:				S			3	Beginning
4	Additions				-			4	Ending
5								5	
6								6	11. Rent to be paid in future years under the current
7	TOTAL				\$			7	rental agreement:
	This amo by the le 9. Option to B. Equipmen 15. Is Mova	ount was calcularingth of the lease Buy: nt-Excluding Trace to the equipment	rtization of lease exp ated by dividing the e YES ransportation and F rental included in b vable equipment:	total amount to l	e amortized Terms:	Trash Compactor - 29			Fiscal Year Ending Annual Rent 12.
	C. Vehicle R	ental (See instr							
	1		2 Model Year		3 Monthly Lease	4 Rental Expense			
	Use		and Make		Payment	for this Period			* If there is an option to buy the building,
17	0.50			\$		\$	17		please provide complete details on attached
18					N/A		18		schedule.
19							19		
20							20		** This amount plus any amortization of lease
21	TOTAL			\$		\$	21		expense must agree with page 4, line 34.

Facility Name Year Ended **Champaign County Nursing Home** Schedule 14A

11/30/2003

Equipment Leasing Recap

Description of Equipment	Amount
Trash Compactor	2,948
Mattress	3,065
Compressor	130

Total per General Ledger 6,143

	ame & ID Number Champaign County				#	0001636	Report Perio	d Beginning:	12/01/2002	Ending:	11/30/200
XIII. EXP	ENSES RELATING TO NURSE AIDE TRAINING	G PROGRAMS (See in	nstructions.)								
A. T	YPE OF TRAINING PROGRAM (If aides are train	ned in another facility	program, attach a	schedule listing t	he facility	name, addre	ss and cost per a	nide trained in t	hat facility.)		
	1. HAVE YOU TRAINED AIDES DURING THIS REPORT	YES 2	. CLASSROOM	PORTION:			3.	CLINICAL PO	ORTION:	_	
	PERIOD? It is the policy of this facility to only	X NO	IN-HOUSE PR	OGRAM				IN-HOUSE PR	OGRAM		
	hire certified nurses aides. If "yes", please complete the remainder		IN OTHER FA	CILITY				IN OTHER FA	CILITY		
	of this schedule. If "no", provide an explanation as to why this training was		COMMUNITY	COLLEGE				HOURS PER A	AIDE		
	not necessary.		HOURS PER A	AIDE							
В. Е.	XPENSES	ALLOCATI	ON OF COSTS	(d)			C. CON	TRACTUAL I	NCOME		
		1	2	3		4		In the box belo			
			cility							,	
		Drop-outs	Completed	Contract		Total		\$]	
1	Community College Tuition	\$	\$	\$	\$						
	Books and Supplies						D. NUM	IBER OF AIDE	S TRAINED		
3	Classroom Wages (a)										
4	Clinical Wages (b)							COMPLET			
	In-House Trainer Wages (c)							1. From this fac			
6	Transportation							2. From other f			
7	Contractual Payments				1			DROP-OU	TS		

STATE OF ILLINOIS

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(e)

(c) For in-house training programs only. Do not include fringe benefits.

7 Contractual Payments 8 Nurse Aide Competency Tests

10 SUM OF line 9, col. 1 and 2

9 TOTALS

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

1. From this facility

2. From other facilities (f)

TOTAL TRAINED

Page 15

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

0001636 Report Period Beginning:

Page 16 12/01/2002 Ending: 11/30/2003

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4		5	6	7	8	
		Schedule V	Stafi	f		Outsid	Outside Practitioner		Supplies			
	Service	Line & Column	Units of		Cost	(other th	nan cons	sultant)	(Actual or)	Total Units	Total Cost	
	_	Reference	Service			Units		Cost	Allocated)	(Column 2 + 4)	(Col. $3 + 5 + 6$)	
1	Licensed Occupational Therapist	10A(1, 2, 3)	220 hrs	\$	1,550	5,912	\$	85,385	\$ 414	6,132	87,349	1
	Licensed Speech and Language											
2	Development Therapist	10A(3)	hrs			2,964		42,831		2,964	42,831	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	10A(2, 3)	hrs			9,524		137,583	575	9,524	138,158	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
			# of									
9	Pharmacy	39(2)	prescrpts						123,794		123,794	9
	Psychological Services											
	(Evaluation and Diagnosis/											
10	Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Exceptional Care Program											12
13	Other (specify):											13
14	TOTAL			\$	1,550	18,400	\$	265,799	\$ 124,783	18,620	392,132	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Champaign County Nursing Home

Provider #: 0001636 12/01/2002to 11/30/2003

Schedule 16A

XIV. Special Services Line 13 Other (specify):

	Line	Outside F	Practioner	
Service	Reference	Units	Cost	Supplies
	L39, C3			
Total			0	0

See Accountants' Compilation Report

STATE OF ILLINOIS

Page 17 11/30/2003 **Champaign County Nursing Home** Report Period Beginning: 12/01/2002 Facility Name & ID Number 0001636 **Ending:** (last day of reporting year)

XV. BALANCE SHEET - Unrestricted Operating Fund.

This report must be completed even if financial statements are attached. As of 11/30/2003

	This report must be completed even if financial statements are attached.							
		1			2 After			
		_	Operating		Consolidation*			
	A. Current Assets							
1	Cash on Hand and in Banks	\$	1,477,525	\$	1,477,525	1		
2	Cash-Patient Deposits		16,862		16,862	2		
	Accounts & Short-Term Notes Receivable-							
3	Patients (less allowance 71,774)		996,887		996,887	3		
4	Supply Inventory (priced at)					4		
5	Short-Term Investments		25,739		25,739	5		
6	Prepaid Insurance					6		
7	Other Prepaid Expenses		36,838		36,838	7		
8	Accounts Receivable (owners or related parties)					8		
9	Other(specify): See attached		12,504		12,504	9		
	TOTAL Current Assets							
10	(sum of lines 1 thru 9)	\$	2,566,355	\$	2,566,355	10		
	B. Long-Term Assets							
11	Long-Term Notes Receivable					11		
12	Long-Term Investments					12		
13	Land		2,100		2,100	13		
14	Buildings, at Historical Cost		6,228,446		6,228,446	14		
15	Leasehold Improvements, at Historical Cost		132,756		132,756	15		
16	Equipment, at Historical Cost		2,002,941		2,002,941	16		
17	Accumulated Depreciation (book methods)		(6,329,212)		(6,329,212)	17		
18	Deferred Charges					18		
19	Organization & Pre-Operating Costs					19		
	Accumulated Amortization -							
20	Organization & Pre-Operating Costs					20		
21	Restricted Funds					21		
22	Other Long-Term Assets (spcConst. In Progress		170,406		170,406	22		
23	Other(specify):					23		
	TOTAL Long-Term Assets							
24	(sum of lines 11 thru 23)	\$	2,207,437	\$	2,207,437	24		
	TOTAL ASSETS	1						
25	(sum of lines 10 and 24)	\$	4,773,792	\$	4,773,792	25		

		1	perating	2 After Consolidation*	
	C. Current Liabilities				
26	Accounts Payable	\$	195,730	\$ 195,730	26
27	Officer's Accounts Payable				27
28	Accounts Payable-Patient Deposits		16,922	16,922	28
29	Short-Term Notes Payable				29
30	Accrued Salaries Payable		345,382	345,382	30
	Accrued Taxes Payable				
31	(excluding real estate taxes)				31
32	Accrued Real Estate Taxes(Sch.IX-B)				32
33	Accrued Interest Payable				33
34	Deferred Compensation				34
35	Federal and State Income Taxes				35
	Other Current Liabilities(specify):				
36	Due to other funds		215,901	215,901	36
37					37
	TOTAL Current Liabilities				
38	(sum of lines 26 thru 37)	\$	773,935	\$ 773,935	38
	D. Long-Term Liabilities				
39	Long-Term Notes Payable				39
40	Mortgage Payable				40
41	Bonds Payable				41
42	Deferred Compensation				42
	Other Long-Term Liabilities(specify):				
43					43
44					44
	TOTAL Long-Term Liabilities				
45	(sum of lines 39 thru 44)	\$		\$	45
	TOTAL LIABILITIES				
46	(sum of lines 38 and 45)	\$	773,935	\$ 773,935	46
47	TOTAL EQUITY(page 18, line 24)	\$	3,999,857	\$ 3,999,857	47
	TOTAL LIABILITIES AND EQUITY	Ý			
48	(sum of lines 46 and 47)	\$	4,773,792	\$ 4,773,792	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Line 9 - Other

Due from other funds	5,900
Due from other government units	78
Due from accounts payable fund	6,526
Total - Line 9	12,504

0001636

F CI	IANGES IN EQUITY			
			1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	3,941,130	1
2	Restatements (describe):			2
3				3
4				4
5				5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	3,941,130	6
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)		58,728	7
8	Aquisitions of Pooled Companies			8
9	Proceeds from Sale of Stock			9
10	Stock Options Exercised			10
11	Contributions and Grants			11
12	Expenditures for Specific Purposes			12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment			14
15	Other (describe) Rounding		(1)	15
16	Other (describe)			16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$	58,727	17
	B. Transfers (Itemize):			
18				18
19				19
20				20
21				21
22				22
23	TOTAL Transfers (sum of lines 18-22)	\$		23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$	3,999,857	24

3,999,857 24 *
Operating Entity Only

^{*} This must agree with page 17, line 47.

Ending:

0001636 XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached. Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue All Levels of Care	\$ 8,957,183	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,957,183	3
	B. Ancillary Revenue		
4	Day Care	213,906	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 213,906	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	123,582	10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	49,526	13
14	Non-Patient Meals	3,014	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	96,368	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 272,490	23
	D. Non-Operating Revenue		
24	Contributions	16,093	24
25	Interest and Other Investment Income***	11,879	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 27,972	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached	689,893	28
28a	Inter-fund transfer from General Account	40,407	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 730,300	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,201,851	30

			2	
	Expenses		Amount	
	A. Operating Expenses			
31	General Services		2,350,365	31
32	Health Care		4,962,267	32
33	General Administration		2,214,271	33
	B. Capital Expense			
34	Ownership		268,287	34
	C. Ancillary Expense			
35	Special Cost Centers		233,506	35
36	Provider Participation Fee		114,427	36
	D. Other Expenses (specify):			
37				37
38				38
39				39
40	TOTAL EVDENICE: (6	10 142 122	40
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$	10,143,123	40
41	Income before Income Taxes (line 30 minus line 40)**		58,728	41
42	Income Taxes			42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$	58,728	43

This must agree with page 4, line 45, column 4.

Does this agree with taxable income (loss) per Federal Income No If not, please attach a r Facility files as part of County return If not, please attach a reconciliation. Tax Return?

^{***} See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a SEE ACCOUNTANTS' COMPILATION REPORT detailed explanation.

^{****}Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Champaign County Nursing Home Facility #0001636 11/30/03

Page 19 - Line 28 - Other Operating Revenue

<u>Description</u>	Amount
Taxes: Current -Nursing Home	677,910
Mobile Home Tax	1,428
Payment in Lieu of Taxes	296
Local Gvmt: Cunningham Township	129
Resident transportation charge	3,420
Late charges, NSF check charges	4,764
Workers Comp reimbursements	223
Other miscellaneous revenue:	
Candy bar fundraiser	1,200
Jury pay, employee reimbursements , etc.	523
	689,893

Facility Name & ID Number Champaign County Nursing Home

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

(This schedule must cover th	1	2**	3	4		2	CONSCETAINT SERVICES	
	# of Hrs.	# of Hrs.	Reporting Period	Average				N
	Actually	Paid and	Total Salaries,	Hourly				0
	Worked	Accrued	Wages	Wage				P
1 Director of Nursing	2,411	2,430	\$ 73,945	\$ 30.43	1			A
2 Assistant Director of Nursing	2,158	2,175	55,309	25.43	2	35		
3 Registered Nurses	21,116	21,286	467,142	21.95	3	36	Medical Director	Mo
4 Licensed Practical Nurses	31,250	31,502	525,089	16.67	4	37	Medical Records Consultant	
5 Nurse Aides & Orderlies	164,811	165,333	1,985,519	12.01	5	38	Nurse Consultant	
6 Nurse Aide Trainees					6	39	Pharmacist Consultant	
7 Licensed Therapist	120	124	1,550	12.50	7	40	Physical Therapy Consultant	
8 Rehab/Therapy Aides	5,848	5,895	68,143	11.56	8	41	Occupational Therapy Consultant	
9 Activity Director	2,182	2,200	43,763	19.89	9	42	Respiratory Therapy Consultant	
10 Activity Assistants	14,773	14,892	156,262	10.49	10	43	Speech Therapy Consultant	
11 Social Service Workers	8,322	8,389	129,547	15.44	11	44	Activity Consultant	
12 Dietician					12	45	Social Service Consultant	
13 Food Service Supervisor	2,280	2,298	53,857	23.44	13	46	Other(specify)	
14 Head Cook	1,421	1,432	27,239	19.02	14	47		
15 Cook Helpers/Assistants	17,187	17,326	199,986	11.54	15	48		
16 Dishwashers	52,893	53,320	442,337	8.30	16			
17 Maintenance Workers	6,146	6,196	72,606	11.72	17	49	TOTAL (lines 35 - 48)	
18 Housekeepers	38,914	39,228	385,085	9.82	18			
19 Laundry	13,818	13,929	129,251	9.28	19			
20 Administrator	2,197	2,215	91,268	41.20	20			
21 Assistant Administrator					21	C. 0	CONTRACT NURSES	
22 Other Administrative					22			
23 Office Manager					23			N
24 Clerical	23,367	23,556	336,926	14.30	24			C
25 Vocational Instruction					25			P
26 Academic Instruction					26			A
27 Medical Director					27	50	Registered Nurses	
28 Qualified MR Prof. (QMRP)					28	51	Licensed Practical Nurses	
29 Resident Services Coordinator					29	52	Nurse Aides	
30 Habilitation Aides (DD Homes)					30	1		
31 Medical Records	2,084	2,101	20,545	9.78	31	53	TOTAL (lines 50 - 52)	
32 Other Health Ca (See attached)	21,209	21,380	438,207	20.50	32	1		
33 Other(specify) (See attached)	30,083	30,326	369,341	12.18	33			
34 TOTAL (lines 1 - 33)	464,590	467,533	\$ 6,072,917 *	s 12.99	34	SEE AC	COUNTANTS' COMPILATION RE	PORT

B. CONSULTANT SERVICES

		1	2	3	
		Number	Total Consultant	Schedule V	
		of Hrs.	Cost for	Line &	
		Paid &	Reporting	Column	
		Accrued	Period	Reference	
35	Dietary Consultant	456	\$ 23,939	1(3)	35
36	Medical Director	Monthly	4,200	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	306	3,600	10(3)	39
40	Physical Therapy Consultant	158	9,480	10A(3)	40
41	Occupational Therapy Consultant	98	5,880	10A(3)	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	49	2,940	10A(3)	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,067	\$ 50,039		49

C. CONTRACT NURSES

Number	Schedule V	
	Schedule v	
of Hrs. Total	Line &	
Paid & Contract	Column	
Accrued Wages	Reference	
50 Registered Nurses 553 \$ 24,652	10(3)	50
51 Licensed Practical Nurses 1,458 50,018	10(3)	51
52 Nurse Aides 204 4,484	10(3)	52
53 TOTAL (lines 50 - 52) 2,215 \$ 79,154		53

^{*} This total must agree with page 4, column 1, line 45.

^{**} See instructions.

Champaign County Nursing Home Facility #0001636 11/30/03

Page 20 - Lines 32 & 33 - Other Wages

	Actually Worked	Paid & Accrued	Total Salary & Wages	Hourly Wage
Line 32 - Other Health Care				
Restorative Care Coordinator	2,317	2,336	49,693	21.27
Dental Hygienist	1,584	1,597	35,619	22.30
Care Plan Coordinator	1,258	1,268	24,859	19.60
QA/Staff Development Coord.	2,113	2,130	50,504	23.71
Nursing Services Coordinator	9,848	9,927	237,470	23.92
Unit Secretary	4,089	4,122	40,062	9.72
	21,209	21,380	438,207	20.50

<u>Line</u>	<u> 33 -</u>	<u>Other</u>	<u>Wages</u>

Barber & Beauty	4,730	4,768	49,138	10.31
Adult Day Care	11,133	11,223	125,230	11.16
Child Day Care	14,220	14,335	194,973	13.60
	30,083	30,326	369,341	12.18

STATE OF ILLINOIS			Pag	ge 21
11 0001727	D D D	13/01/3003	17 . 1*	11/20/2002

				STATE	OF ILLINOIS					Pag	e 21
	Champaign County Nursing I	Iome		# 000163	36	Repor	t Period Begi	nning:	12/01/2002	Ending:	11/30/2003
XIX. SUPPORT SCHEDULES											
A. Administrative Salaries	Owners	hip		D. Employee Benefits and Pay					s, Subscriptions and F	Promotions	
Name	Function %		Amount	Descript			Amount		Description		Amount
Jeremy Maupin	Administrator 0	\$	91,268	Workers' Compensation Insu		_ \$	292,312	IDPH Licen		\$	
				Unemployment Compensation	n Insurance		45,901		Employee Recruitme		6,89
				FICA Taxes			412,703		Worker Background		
				Employee Health Insurance			332,736	_	f checks performed	<u>33</u>)	23
				Employee Meals			5,918		th Care Assn. Dues		11,82
				Illinois Municipal Retirement	t Fund (IMRF)*		214,101	Miscellaneo			1,20
				Employee Morale			14,129	Miscelleneou			19
TOTAL (agree to Schedule V, line				Employee Physicals & Labs			3,870		us Subscriptions		1,13
(List each licensed administrator s	separately.)	\$	91,268	Employee Moving Expense			133	Other Adver	rtising		1,70
B. Administrative - Other									ing Home Assoc of IL		2,0
								Less: Publi	c Relations Expense		(1
Description			Amount					Non-a	llowable advertising		(1,7
Champaign County - Treasury Se	rvices	\$	6,260					Yellov	v page advertising	(
Champaign County - Audit & Acc	counting Services		40,301								
				TOTAL (agree to Schedule V	7,	\$	1,321,803	,	TOTAL (agree to Sch	. V, \$	23,3
				line 22, col.8)					line 20, col. 8)		
TOTAL (agree to Schedule V, line	e 17, col. 3)	\$	46,561	E. Schedule of Non-Cash Con	npensation Paid			G. Schedule	of Travel and Semina	ır**	
(Attach a copy of any managemen	t service agreement)	•		to Owners or Employees							
C. Professional Services				1				1	Description		Amoun
Vendor/Payee	Type		Amount	Description	Line #		Amount		•		
Area Wide Reporting Serv.	Legal	\$	322			\$		Out-of-State	Travel	\$	
Edwin H Benn, Attorney	Legal		2,531		_						
Fed. Mediation & Conciliation	Legal		25	N/A			-				
James Robt Cox, Arbitrator	Legal		300					In-State Tra	vel		
American Arbitration Assoc	Legal		175								
Edward J Harrick, PhD	Legal		360								
Medline Industries, Inc.	Medicare Billing Service		1,750								
Altschuler, Melvoin, & Glasser	Accounting Services		6,588					Seminar Ex	pense		
Champaign Co Treasurer	Accounting Support		8,326					,	P =		
American Express TBS	Consulting		185					See Attach	ed		8,2
Egix	Internet Service		176					Secretario			3,2
Total - Sch21A	Internet Service		11,255					Entertainme	ent Expense		
TOTAL (agree to Schedule V, line	2 19. column 3)		11,200	TOTAL		S		Zater taname	(agree to Sch. V.		
(If total legal fees exceed \$2500 att		Q	31,993	TOTAL		Ψ		TOTAL	line 24, col. 8)	s	8,2
Ti total regal ices exceed \$2500 att	men copy of invoices.)	Φ.	31,773	* Attach copy of IMRF notific	ations			**See instruc		9	0,22

* Attach copy of IMRF notifications SEE ACCOUNTANTS' COMPILATION REPORT

Champaign County Nursing Home

Provider #: 0001636 12/01/2002 to 11/30/2003

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

<u>Vendor/Payee</u> Total Page 21	<u>Type</u>	Amount 20,738.00
Jeremy Maupin Ivans Senior Living Systems Menu Systems Arends & Sons Ban-Koe Systems Capital One, FSB Champaign Co. Treasurer Total (agree to Schedule V, line 19,	•	263.00 2,830.00 6,468.00 258.00 35.00 313.00 72.00 1,016.00 31,993.00
Allocated to Day Care and elin	ninated	(813.00)
Total (agree to Schedule V, line 19,	column 8)	31,180.00

Report Period Beginning: 12/01/2002

Ending:

Page 22 11/30/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3). (See instructions.)

	(See instructions.)	2	3	4	5	6	7	8	9	10	11	12	13
	1	Month & Year	3		, 		,			tized Per Year		12	13
	Improvement Type	Improvement Was Made	Total Cost	Useful Life	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3								N/A					
4													
5													
6													
7													
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13													
14	•												
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

acilit	y Name & ID Number Champaign County Nursing Home	STA	TE O #	F ILLINOIS 0001636	Report Period Beginning:	12/01/2002	Ending:	Page 23 11/30/2003
	Are there any dues to nursing home associations included on the cost report? Yes Are there any dues to nursing home associations included on the cost report? Yes If YES, give association name and amount. See attached 13,883	`	1	the Department of the Ancillary S	supplies and services which are of the f Public Aid, in addition to the daily rection of Schedule V? Yes	ate, been prope	erly classified	for
(3)	Did the nursing home make political contributions or payments to a politica action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A	() 1 i	the patient census is a portion of the	building used for any function other listed on page 2, Section B? Yes-Sec building used for rental, a pharmacy, explains how all related costs were al	e page 8A day care, etc.)	For example If YES, attac	e,
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A	(Indicate the cost on Schedule V. related costs?		ssified to employmeal income to the amount.	been offset ag	ainst
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period? Yes 7	((16)	Travel and Trans		No		
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 81,998 Line 10(2)			If YES, attach	a complete explanation. separate contract with the Departmen			
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.		(program during c. What percent of	g this reporting period. \$ N/A f all travel expense relates to transpor sage logs been maintained? Adequa	tation of nurses	s and patients	? 0
(8)	Are you presently operating under a sale and leaseback arrangement: If YES, give effective date of lease. No No		(e. Are all vehicle times when no	s stored at the nursing home during th	e night and all	othei	
(9)	Are you presently operating under a sublease agreement? YES X N	Ю		out of the cost		· ·		No
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facili IDPH license number of this related party and the date the present owners took over	ity,	1	Indicate the	amount of income earned from ponduring this reporting period.	roviding suc		
	N/A	(performed by an independent certification performed by an independent certification.		unting firm? The instruct	
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 114,427 This amount is to be recorded on line 42 of Schedule V.				e that a copy of this audit be included		eport. Has thi	
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.	(Have all costs whout of Schedule V	ich do not relate to the provision of lo ?? Yes	ng term care b	een adjusted o	ou ^r
	SEE ACCOUNTANTS' COMPILATION REPORT	(`´	performed been a	are in excess of \$2500, have legal inv ttached to this cost report? Yes nd a summary of services for all archi		,	ices

Champaign County Nursing Home

Provider #: 0001636 12/01/2002 to 11/30/2003

Schedule 23A

XX. GENERAL INFORMATION

2. Nursing Home Association Dues

<u>Vendor/Payee</u>	<u>Amount</u>
Illinois Health Care Assoc.	11,823
County Nursing Home Assoc. of IL	2,060

Total 13,883

RECONCILIATION REPORT	Champaign C	County Nurs	11:26 AM	11/04/05									
ITEM	Mahin 4	0	\/-t 0	D##	DECL!! TO	COMPARE OF	SUB-	LINE	COL.	WITH CELL	SUB-	LINE	COL.
ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SCHED.	NO.	NO.	WITH CELL	SCHED.	NO.	NO.
Adjustment Detail	-560,018	equal to	-560,018	0	O.K.	Pg5 Z22	В.	37	1	Pg4 K29	N/A	45	7
Interest Expense	0	equal to	0	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	0	equal to	0	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	229,475	equal to	229,475	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	Α.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	6,143	equal to	6,143	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv Staff Wages	1,550	equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	286,638	equal to	286,638	0	O.K.	Pg16 Z12+Z14	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv Supplies	124,783	equal to	124,783	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	2,350,365	equal to	2,350,365	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	4,962,267	equal to	4,962,267	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	2,214,271	equal to	2,214,271	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	268,287	equal to	268,287	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	233,506	equal to	233,506	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21H24+F	N/A	38to41+43	4
Income Stat. Prov. Partic.	114,427	equal to	114,427	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	3,127,549	equal to	3,633,899	-506,350	FAILED	Pg20 K11K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	1,550	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	200,025	equal to	200,025	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	129,547	equal to	129,547	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	723,419	equal to	723,419	0	O.K.	Pg20 K22K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	72,606	equal to	72,606	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	385,085	equal to	385,085	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	129,251	equal to	129,251	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	91,268	equal to	91,268	0	O.K.	Pg20 K30K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	336,926	equal to	336,926	0	O.K.	Pg20 K33K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	6,072,917	equal to	6,072,917	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	23,939	< or = to	23,939	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	4,200	< or = to	4,200	0	O.K.	Pg20 X13	В.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	82,754	< or = to	150,694	-67,940	O.K.	Pg20 X14X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	4,164	-4,164	O.K.	Pg20 X21	В.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	В.	45	2	Pg3 G22	N/A	12	3
Supp. Sched Admin. Salar.	91,268	equal to	91,268	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched Admin. Other	46,561	equal to	46,561	0	O.K.	Pg21 I24	В.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched Prof. Serv.	31,993	equal to	31,993	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched Benefit/Taxes	1,321,803	equal to	1,321,803	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched Sched of dues	23,377	equal to	23,377	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched Sched. of trav	8,221	equal to	8,221	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	114,427	equal to	114,427	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	5,918	< or = to	-59,175	65,093	FAILED	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	5,918	equal to	5,918	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29U31	В.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	5,537	equal to	5,537	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	0	equal to	0	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y40	B.	14	8
Total loan balance	0	equal to	0	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27	N/A	29+39-41	2
Real estate tax accrual	0	equal to		0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	2,100	equal to	2,100	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	6,361,202	equal to	6,361,202	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	2,002,941	equal to	2,002,941	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	6,329,212	equal to	6,329,212	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	3,999,857	equal to	3,999,857	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	58,728	equal to	58,728	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	, -	0	O.K.	Pg22 F31-J318	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	4,773,792	equal to	4,773,792	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1
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Total Served Jahren 2 (100,001 Carlis, Sav 20 - Audit Adj	2. Similarly the first of the growth organization by the proportion of the growth of the Control Minimum. 3. All the proportion of the parameter to pur- tioning and union accessed to go now thoughout describes a property by prior was and growth organization.	201 (484) (484) 201 (486) (486) 201 (470) (486) 201 (470) (486) 201 (486) 201 (486) 201 (486) 201 (486) 201 (486)	
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Capital Rate Data Change print Orientation!	TO THE COST REPOR	THE CAPITAL CALC. THAT RTTH	110405	11:26:46 AM		0	APITAL CALCULATIONS
Facilty Name: Champaign Crumty Nursing Home	COSTS INCLUDED OF	N PAGES 12 THRU 12D ST		101	0001636	A	Determine the base year for your building from Work Table A
HSA No.:	4 Own	or Rent? (O or R) O		Own or Rent Beginning:		9.	Determine the Building Specific historical cost per bed:
IF RENTED, have facilities been continously rented from an unveilated party since prior to January 5, 1978 (Y or N); or since the first day of operation for buildings continued since January 3, 1978?	N			-			1. Work Table A, Line 24, Column (B) 2. Trail (consent exist from cost report Page 2, Line 7, column 9 2. Line 1 divided by Line 2 4. Regional construction inflator from Table 2 6. Relating specific instruction for the red (Line 3 * Line 4, nound to even \$)
Cost Report Pd: Beoin		need Beds:		Total Patient Days % Occupied	73,824	c	Obtain the Uniform Building Value from Table 1
End	1100280	and see cope.		Capital Days	82,486	0.	The capital rate will be calculated through a blending of the uniform building value from Line C and the building specific historical cost
1989 Property Tax COST:	(Actu	al dolar amount 1989 taxes	3				per bed from Line RS
1991 Property Tax RATE:		ted dollar amount divided by 991 capital days)					Suilding specific historical cost from Line BS Uniform building value from Line C
FY 1991 Capital Rate:	(From	n forn 797)					2. Add Lines 1 and 2

CAPITAL CALCULATIONS	Calculation
	Column
A. Determine the base year for your building from Work Table A	19
Determine the Building Specific historical cost per bed:	
1. Work Table A, Line SH, Column (B)	63612
Total licensed beds from cost report Page 2, Line 7, column 3 Line 1 divided by Line 2	20 17 526 17
Line 1 divided by Line 2 Regional construction inflator from Table 2	1.
5. Stuilding specific historical Cost ber bed (Line 3 * Line 4, round to even \$)	502
C. Obtain the Linform Building Value from Table 1	150
D. The capital rate will be calculated through a blending of the uniform	
building value from Line C and the building specific historical cost per bed from Line ΩS	
1. Suiting specific historical cost from Line SS	502
Uniform building value from Line C Add Lines 1 and 2	150 653
Divide by 2 to obtain average	220
5. Enter 120% of line C	190
6. The blended value is the lesser of Line 4 or Line 5	190
E. Divide the blended value from step D by 209 days to obtain a per diem	\$3.32
blanded value investment	
F. Multiply the per diem blended value from step E by the applicable rate of	
neturn to obtain the building rate factor. (The rate of return is 11% for	
1979 and later base years and 9:13% for 1978 and older base years.)	
G. Add \$2.50 to Line F for equipment, rent, whicle and working capital.	
H. Add Lines F & G to obtain the preliminary capital rate	
 Implementation Capital Pate. (This step does not apply if the facility has been constructed or punchased after FYR1.) 	
1. Enter the FY 91 capital rate	
2. Subtract the FY 91 property tax rate	
FY 91 rate without tax Multiply Line () by 115%	x 1.9%
Muspy Line D by 110% Implementation capital rate	2 1.19%
J. Property Tax Property taxes are taken from the Long Term Care Property Tax Statement	
which was submitted to the Department of Public Aid during PYRD.	
Reimbursement for real estate taxes is based upon the actual 1991 taxes for	
which the nursing homes were assessed. The formula used is a follows:	
Property Tax Expense (Long Term Care Property Tax Statement, Column D, Total.)	
Divided by: Capital Days (see below)	92,46
Equals: Per Diem Cost Times: Property Tax Inflator (Table 2)	\$0.0 1.023
Times: Property Lax Illiator (Labe 3) Equals: Updated Property Tax Cost	1.003
Capital Dava	
The capital days are the higher of the actual census (Page 2, Schedule III-B.	
Column 5, Line 14) or 92% of licensed bed days (page 2, Schedule III-A, Column 4, Line 7 * 93.)	
Total Patient Days Total Licensed Bed Days * 93	73,62
2. Total Licensed wed Days * 50 2. Capital Days (higher of Line 1 or Line 2)	82.40
S. Captai Days (righer of Line 1 or Line 2) K. Total Capital Sote for FY 94	82,40
Enter the greater of the simplified system rate from Line H or the	
 sinter the greater of the simplified system rate from Line H or the implementation capital rate from Line I 	
2. Add Property Tax from Line JS	
Total capital rate (add Lines 1 & 2)	

Work Table A	Calculation Column	WINGER TABLE A Year Acquired (A) Land 2 dight only	Cost (A) "(i) Linked (i) (i) Page	Year Acquired Columns (A) Cost (A)*(B) Linked Last2 digits only (B) (C) Page	TABLE 1 Table 1 Uniform building Value Linform Building Value	TABLE 2 Connection inflamms by your and ISEA (Note: Use the HISEO INSIDE SET AN APPLIED TO 15 (AND APPLIED SET) (For the PAT Naturally Salady) Set (Calabidino Patala)	TABLE 3 Property Tax Inflator	TABLE 4 Table 2 column
Let a Comment (Let a	\$20.000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	1	1.4 1.4	1.1 1.1	1454 8 mg	100 Comm. 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
e from Line H or the	73,804 80486 82,466 8.37 0 8.37	500 500 500 500 500 500 500 500 500 500	98 19228 1911-28 12A 68 24 144 194272 12A 68 25 144 194272 12A 68 25 144 1942 12A 68 25 144 1942 146666 12A 68 25 144 1942 146666 12A 68 25 146 14666 12A 68 25 146 14666 12A 68 25 146 178882 12A 68	164 0 0 0 1000 165 0 0 0 1000 167 0 0 0 0 1000 167 0 0 0 0 1000 168 0 0 0 0 1000 168 0 0 0 0 1000 169 0 0 0 1000 169 0 0 0 1000 169 0 0 0 1000 169 0 0 0 1000 169 0 0 0 1000 169 0 0 0 1000 169 0 0 0 1000 169 0 0 0 1000 169 0 0 0 1000 169 0 0 0 1000 169 0 0 0 1000 169 0 0 0 1000 169 0 0 0 1000				
		22 22 22 22 22 22 22 22 22 22 22 22 22	14	Manufacture Colonial - San Yue San Yue - 1960				

Construction info	lators by year and	NGA.			Property Tax Infl	ator	Table 2 column
	990 inflators for al		101				
(For the FY94 N	ursing Facility Rat	Calculation Pack	iat)				
Year 1960	1, 2 & 10	2,445	629	4,7,849	HSA	Rate	HSA
	6.26	6.08		6.54	-	1.06723	
1961	5.67	5.52	5.66	5.87	2	1.0395	2
1962	5.67	5.52	5.66	5.87	3	1.0333	3
1963	5.67	5.52	5.66	5.87	4	1.03302	4
1964	5.67	5.52	5.66	5.87	5	1.03753	5
1965	5.67	5.52	5.66	5.87	4	1.02368	4
1966	5.36	5.23	5.35	5.55	7	1.02054	7
1967	5.1	4.97	5.00	5.28		1.02913	
1968	4.85	4.71	4.83	5.03	9	1.01315	9
1909	4.61	4.48	4.59	4.79	10	1.0915	10
1970	4.38	4.25	4.36	4.56	11	1.03527	11
1971	4.01	3.89	3.99	4.15			
1972	2.64	3.53	3.63	3.78			
1973	3.36	3.26	3.36	2.48			
1974	3.08	3	3.09	3.19			
1975	2.93	2.77	2.8	291			
1976	2.72	2.65	2.74	2.92			
1977	2.57	2.48	2.55	2.68			
1979	2.37	2.29	2.38	2.49			
1979	2.19	2.12	2.21	2.32			
1990	1.96	1.92	2.02	2.08			
1981	1.8	1.76	1.86	1.91			
1982	1.67	1.63	1.72	1.76			
1963	1.54	1.5	1.57	1.65			
1984	1.51	1.47	1.55	1.62			
1985	1.48	1.45	1.5	1.59			
1986	1.46	1.42	1.46	1.55			
1967	1.44	1.4	1.43	1.52			
	1.4						
1989	1.35	1.33	1.35	1.41			
1990	1.32	1.21	1.33	134			
1992	1.29	129	1.27	1.20			
1993	1.25	1.24	1.25	1.23			
1994	122	1.22	1.22	1.19			
		1.2	1.19	1.17			
1996	1.12	1.11	1.13	1.12			
1997	1.1	1.09	1.1	1.1			
1998	1.09	1.07	1.07	1.07			
2000	1.02	1.02	1.02	1.03			
2001 2002	1.00	1.00	1.00	1.00			
2002	1.00	1.00	1.00	1.00			

						Reclass-	Reclassified		Adjusted
		Salaries	Supplies	Other	Total	ifications	Total	Adjustments	Total
1. Dietary		723,419	73,924	23,939	821,282	0	821,282	-3,502	817,780
Food Purchase		0	456,164	0	456,164	0	456,164	-23,071	433,093
Housekeeping		385,085	28,534	0	413,619	0	413,619	-2,595	411,024
4. Laundry		129,251	26,221	0	155,472	0	155,472	0	155,472
Heat and Other Utilities		0	0	326,921	326,921	0	326,921	-28,348	298,573
6. Maintenance		72,606	12,264	92,037	176,907	0	176,907	-8,633	168,274
Other (specify)*		0	0	0	0	0	0	0	0
8. Total General Services		1,310,361	597,107	442,897	2,350,365	0	2,350,365	-66,149	2,284,216
Medical Director		0	0	4,200	4,200	0	4,200	0	4,200
Nursing & Medical Records		3,633,899	225,591	,	4,010,184	0	,		,
•						0	, ,		, ,
10a. Therapy		1,550	989	,	286,638		,		,
11. Activities		200,025	266		204,455	0	- ,	,	,
12. Social Services		129,547	27		129,574	0	- , -		,
13. Nurse Aide Training		0	0		0	0			
14. Program Transportation		0	0		0	0			
Other (specify)*		320,203	2,091	4,922	327,216	0	- , -	,	
16. Total Health Care & Programs		4,285,224	228,964	448,079	4,962,267	0	4,962,267	-328,416	4,633,851
17. Administrative		91,268	0	46,561	137,829	0	137,829	-1,041	136,788
18. Directors Fees		0	0	,	0	0			,
19. Professional Services		0	0		31,993	0			31,180
20. Fees, Subscriptions & Promotio	n	0	0	- ,	25,248	0	- ,		- ,
21. Clerical & General Office		336,926	15,174	-, -	415,515	0	-, -		,
22. Employee Benefits & Payroll		000,520	0,174	,	1,380,978	0	-,		,
23. Inservice Training & Education		0	0		2,289	0	, ,		
24. Travel and Seminar		0	0	,	9,018	0	,		,
25. Other Admin. Staff Trans		0	0	-,	1,696	0	-,		-,
26. Insurance-Prop.Liab.Malpractic	^	0	0	,	209,705	0	,		,
	C	0	0	,	209,703	0	,		,
27. Other (specify)* 28. Total General Adminis		428.194				0			
26. Total General Adminis		420,194	15,174	1,770,903	2,214,271	U	2,214,271	-73,610	2,140,661
29. Total General Administrative		6,023,779	841,245	2,661,879	9,526,903	0	9,526,903	-468,175	9,058,728
30. Depreciation		0	0	262,144	262,144	0	262,144	-32,669	229,475
31. Amortization of Pre-Op. & Org.		0	0	0	0	0	0	0	0
32. Interest		0	0	0	0	0	0	0	0
33. Real Estate		0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds		0	0		0	0			0
35. Rent - Equipment & Vehicles		0	0		6.143	0			
36. Other (specify):*		0	0	-,	0,110	0	-, -		-,
37. Total Ownership		0	0		268,287	0			-
o rotal ownorship		·	· ·	200,201	200,20.	·	200,20.	02,000	200,010
38. Medically Necessary T		0	0	0	0	0	0	0	0
Ancillary Service Cent		0	123,794	0	123,794	0	123,794	0	123,794
40. Barber and Beauty Shop		49,138	1,400	0	50,538	0	,	0	50,538
41. Coffee and Gift Shops		0	0	0	0	0	0	0	0
	42	0	0	114,427	114,427	0	114,427	0	114,427
43. Other (specify):*		0	0	59,174	59,174	0	59,174	-59,174	0
44. Total Special Cost Ce		49,138	125,194	173,601	347,933	0	347,933	-59,174	288,759
45. Grand Total		6,072,917	966,439	3,103,767	10,143,123	0	10,143,123	-560,018	9,583,105

	Operating	After Consolidation
General Service Cost Center		
Cash on hand and in banks	1,477,525	1,477,525
2. Cash - Patient Deposits	16,862	
3. Accounts & Notes Recievable	996,887	
4. Supply Inventory	0	
5. Short-Term Investments	25,739	
6. Prepaid Insurance	0	
7. Other Prepaid Expenses	36,838	
8. Accounts Receivable-Owner/Related Party	0	,
9. Other (specify):	12,504	
10. Total current assets	2,566,355	
LONG TERM ASSETS	, ,	, ,
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	0
14. Buildings, at Historical Cost	6,228,446	6,228,446
15. Leasehold Improvements, Historical Cost	132,756	
16. Equipment, at Historical Cost	2,005,041	
17. Accumulated Depreciation (book methods)	-6,329,212	
18. Deferred Charges	0	
19. Organization & Pre-Operating Costs	0	
20. Accum Amort - Org/Pre-Op Costs	0	
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	170,406	170,406
23. other (specify):	0	
24. Total Long-Term Assets	2,207,437	2,207,437
25. Total Assets	4,773,792	
CURRENT LIABILITIES		
26. Accounts Payable	195,730	195,730
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	16,922	16,922
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	345,382	345,382
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
Other Current Liabilities (specify):	215,901	215,901
Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	773,935	773,935
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	0	
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	0
46.Total Liabilities	773,935	
47.Total Equity	3,999,857	
48.Total Liabilities and Equity	4,773,792	4,773,792

Gross Revenue - All levels of Care Discounts and Allowances for all Levels	Balance per Medicaid Trial Balance 8,957,183 0
Subtotal - Inpatient Care 4. Day Care 5. Other Care for Outpatients 6. Therapy	8,957,183 213,906 0 0
7. Oxygen	0
Subtotal - Anciliary Revenue	213,906
9. Payments for Education10. Other Governmental Grants	0 123,582
11. Nurses Aide Training Reimbursements12. Gift and Coffee Shop	- 0
13. Barber and Beauty Care	49,526
14. Non-Patient Meals	3,014
 Telephone, Television, and Radio Rental of Facility Space 	0 0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	Ö
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	96,368
22. Laundry	0
Subtotal - Other Operating Revenue	272,490
24. Contributions	16,093
25. Interest and Other Investments Income	11,879
Subtotal - Non-Operating Revenue	27,972
27. Other Revenue (specify):	689,893
28. Other Revenue (specify): Subtotal - Other Revenue	40,407 730,300
30. Total Revenue	10,201,851
31. General Services	2,350,365
32. Health Care	4,962,267
33. General Administration	2,214,271
34. Ownership	268,287
35. Special Cost Centers	233,506
35. Provider Participation Fee	114,427
37. Other	0
40. Total Expenses	10,143,123
41. Income Before Income Taxes	58,728
42. Income Taxes	0
43. Net Income or Loss for the Year	58,728

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Page
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23 Provider Participation fee is linked from page 4
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